STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

7. Home Health Services (continued)

(c) where there are no Medicare prevailing charges, an amount established under a State fee schedule in effect June 30, 1988; or
(d) The lowest bid price for the equipment, device, appliance or supply resulting from advertisements requesting bids from qualified vendors to furnish these items.

All payments for medical supplies are deemed payment in full and are excluded from the cost reports.

(3) When a specific item is determined by the Department to be essential to the health of the recipient, and the absence of the item could reasonably be expected to result in a significant deterioration in the recipient's health status, the price limitations described above may be waived if the Department determines the price limitation significantly and adversely affects accessibility of the item.

c. Purchased Durable Medical Equipment, Prosthetic Devices, Orthotic Appliances

(1) When provided by a Home Health Agency or Medical Vendor, reimbursement shall be the lesser of:

(a) billed charges; or
(b) 100% of the 75th percentile of Medicare prevailing charges in effect as of June 30, 1988; or
(c) Where there are no Medicare prevailing charges, an amount established under a state fee schedule in effect June 30, 1988; or
(d) The lowest bid price for the equipment, device, appliance or supply resulting from advertisements requesting bids from qualified vendors to furnish these items.

(2) Necessary repairs, maintenance and replacement of expendable parts of purchased equipment shall be reimbursed at 80% of billed charges.

All payments for durable medical equipment, prosthetic devices, and orthotic appliances are deemed payment in full and are excluded from the cost reports.

d. Rental Equipment

In the case of rental equipment, Medicaid reimburses a monthly rental payment which is ten (10) percent of the Medicaid allowable

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Home Health Services (continued)

purchase fee, except that the following rental only items are reimbursed at the lesser of: billed charges; or the Medicare prevailing monthly rental charge in effect as of June 30, 1988.

(1) Oxygen concentrator
(2) Oxygen system (gas setup)
(3) Oxygen system (gas portable)
(4) Oxygen system (liquid stationary)
(5) Oxygen system (liquid portable)
(6) Ventilator portable (home-use)

All payments for rental equipment are deemed payment in full and are excluded from cost settlement.

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9. Clinic Services

a. Community Mental Health Clinics

Reimbursement shall be based on a differential rate established for the category of service provided. The rate will be set prospectively in July of each year and will be based on the lower of costs or charges for the previous fiscal year, determined according to Medicare principles. On an annual basis, the rate will be trended forward using the Consumer Price Index for outpatient services averaged over the most recent three year period. Annual reimbursement amounts will not be subject to cost settlement.

Payments will not exceed the upper limits pursuant to 42 CFR 447.321.

b. Community Clinics

(1) Community Health Clinics, Community Health Agencies, Community Services Clinics

(a) Medicaid will reimburse providers, except community clinics designated as a nominal provider, the lesser of:

(i) Reasonable allowable cost computed according to Medicare principles of reimbursement, or

(ii) Billed charges.

(b) Community clinics designated as nominal providers will be reimbursed at reasonable allowable cost.

(c) Payment will not exceed the upper limits pursuant to 42 CFR 447.321.

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RATES - OTHER TYPES OF CARE

9. Clinic Services (continued)

(2) Ambulatory Surgical Centers

Payment is for facility services and shall be the lesser of:

(a) billed charges, or

(b) an amount based upon Medicare principles as described in 42 CFR 416.120(c).

In no event shall reimbursement exceed the rates determined pursuant to 42 CFR 416.120(c) and in effect July 1, 1988 or the upper limits pursuant to 42 CFR 447.321.

(3) Community Mental Retardation Clinics

Payment for covered services shall be a prospective fee equal to the lesser of billed charges or a maximum amount established by Medicaid for the type service provided.

Payments will not exceed the upper limits pursuant to 42 CFR 447.321.

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RATES - OTHER TYPES OF CARE

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10. Dental Services

Dental service payment is not to exceed the lesser of:

a. billed amount,
b. 85% of the usual and customary charges accumulated by each individual dentist, or
c. 85% of the 75th percentile of the range of weighted customary charges by dentists in the State (Dental profile) for the 1984 calendar year.

Dental service reimbursement shall not exceed the amount in effect June 30, 1988.

D3088293

TN No. 88-11 DATE/RECEIVED 6/30/88
SUPERCEDES DATE/APPROVED 12/5/88
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12.a. Prescribed drugs

(1) Payment for legend drugs authorized under the program may be made through a contract with one or more pharmacy benefits vendors or directly to participating pharmacies. Payment shall include:

(a) Payment for the cost of legend drugs will be in conformity with 42 CFR 447.331 and will be the lesser of:

(i) Estimated acquisition cost, which is defined as the average wholesale price (AWP), as published in a nationally recognized compendium approved by the State, minus 13% plus a dispensing fee, or

(ii) Maximum allowable cost (MAC), which is defined as the published upper limit of reimbursement which in most cases is the same or lower than that described in 42 CFR 447.332, plus a dispensing fee. (Excluded from aggregate comparison will be any unit doses packaged by the pharmaceutical manufacturer and used in an institutional setting. To assure that payment for the multiple source drugs described in 42 CFR 447.332 does not exceed the aggregate expenditures, an annual report will be prepared to demonstrate compliance.); or

(iii) Tennessee maximum allowable cost (TMAC) plus a dispensing fee, or

(iv) Provider's usual and customary charge, which is defined as the charge to the non-Medicaid patient and which is confirmed via post-payment audits of the provider's prescription files and usual and customary fee schedules by the State Comptroller's Office, or

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(v) If the drug is purchased via contract prices eligible to an inpatient facility and/or non-profit institution, actual invoice price plus a dispensing fee.

(b) The dispensing fee for legend drugs is established at $2.50 for each prescription dispensed by pharmacy providers who comply with State-approved preferred provider credentialing requirements or special exemption requirements and $2.00 for each prescription dispensed by other pharmacy providers, except for approved long-term care unit dose vendors for whom the dispensing fee is established at $6.00 for unit dose prescriptions.

D1059013

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12.d.

Eyeglasses - Payment not to exceed the lower of usual and customary charges or the following:

(a) Qualified providers will be reimbursed forty dollars for the examination and refraction of a patient.

(b) Qualified providers will be reimbursed twenty-two dollars for a pair of single vision (glass or plastic) lenses.

(c) Qualified providers will be reimbursed twenty-four dollars and eighty cents for a pair of bifocal or multifocal vision (glass or plastic lenses).

(d) Qualified providers will be reimbursed the actual acquisition cost for special lenses, which have been prior approved by Medicaid.

(e) Qualified providers will be reimbursed eighteen dollars for a pair of standard frames.

(f) In addition to the above, the provider will receive a dispensing fee of twenty-one dollars for dispensing a pair of eyeglasses.

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

13.d. Rehabilitative Services

For rehabilitative services which are restricted to mental health services provided by eligible providers, on a differential rate established for the category of service provided.

The designated categories of service are outpatient brief, outpatient individual, outpatient group, medical doctor, evaluation-short, evaluation-extended and evaluation-long.

The State assures that it will comply with the upper limit of payment assurance required by 42 CFR 447.321. The rates are cost based and individualized by category of service. Cost records that establish the prospective rate will be maintained and audited annually. The rates will be adjusted in subsequent years to reflect new cost information. The State will not reimburse more than cost.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

17. Nurse-midwife services

a. Medicaid reimbursement to nurse-midwives for covered services will be the lesser of:

1. Billed amount; or

2. 90% of the maximum amount paid to physicians statewide for similar maternity and newborn services.

b. Reimbursement is not available for physician supervision of the nurse midwife when performing uncomplicated maternity and uncomplicated newborn services. In no instance, will Medicaid duplicate reimbursement to a nurse midwife and a physician for delivery of uncomplicated maternity and uncomplicated newborn services to the same recipient during the same maternity and newborn cycle.